

cases, gave it a trial with the happiest results; for, rebellious as the disease had before shown itself, it now became quite manageable. The part affected was rubbed with the ointment every alternate five minutes for two hours night and morning, a cataplasm being afterwards applied. Relief was so prompt and complete, that it was naturally believed the character of the disease had changed; but some cases happening to occur which were treated by the ordinary means displayed all the former virulence. Prior to the mercurial treatment resolution never occurred, and many most unfortunate terminations were observed: but, subsequently, the very reverse took place. After the troops left the locality and returned to their old quarters the disease never reappeared.—*Med. Chirurg. Rev.*, July, 1845, from *Recueil de Mémoires de Med., de Chirurg., et de Pharm., Militaires*, tom. 57.

48. *Fracture of the Leg, the patient walking and riding during twelve days after.*—An adjutant of dragoons, in jumping from a height, came flat upon his feet, and felt a severe pain in the middle of the leg, which obliged him to remain quiet for a few minutes. He soon, however, walked some miles, and for several days after continued to perform the duties of his post, which from the 9th to the 13th of September, were of a peculiarly fatiguing character. During this period there were some pain and swelling, but on the last-named day, while descending a declivity, a bone was heard to snap, and he would have fallen to the ground but for the arm of a friend. Both bones were found fractured towards the lower part of the middle third, the tibia being broken very obliquely. The case was then treated in the usual method, and the patient recovered the perfect use of the limb.—*Ibid.*

49. *Ruptures of Ovarian Cysts.*—Dr. CAMUS, in an interesting memoir read before the Medical Society of Paris, and published in the *Revue Médicale*, (Nov., 1844,) gives the details of a case of encysted dropsy of the right ovary in which the cyst three times spontaneously ruptured, its contents being effused into the peritoneal cavity, and on all three occasions the effused fluid was absorbed.

The subject of this case, a woman about 45 years of age, had laboured under encysted dropsy of right ovary for two years and a half. Purgatives, diuretics, ioduret of potassium, and compression, had alike failed in procuring any benefit. The patient was on the whole, however, in a tolerably comfortable state, till the 17th of January, 1844, when the tumour became the seat of severe pain, accompanied with extreme lassitude, shivering, and slight fever.—(A bleeding prescribed.)

On the 19th, the patient was suddenly seized with severe pain in the abdomen, prolonged shivering, nausea, vomiting, and great restlessness; pulse 126, small and hard, colic, face anxious, as in peritonitis.

On examining the abdomen, M. Camus discovered to his surprise that *its shape was completely altered*: instead of projecting it was flattened at the centre. But the abdomen had gained in size what it had lost in prominence. Percussion yielded a clear sound in the median line in the neighbourhood of the umbilicus, where formerly a dull sound had been heard. At the sides, on the other hand, the clear sound was replaced by a dull one. The undulation of fluid from one side to the other had never been before so perceptible. These remarkable changes were evidently due to rupture of the cyst, and the consequent effusion of the fluid which it contained, into the peritoneal cavity. The encysted dropsy had become converted into a true ascites. Notwithstanding the fears to which this accident gave rise, the peritonitis terminated happily in the course of two or three days.

On the 22d and 23d, the urine, hitherto scanty, became clear and limpid, and in such quantity as to fill the vessel five times in the twenty-four hours. During this time, the abdomen also lost from two to three inches daily in circumference, and became more and more pliant.

On the 1st February, twelve days after the rupture, the urine still continuing to be passed in abundance, the existence of fluid in the peritoneal cavity could no longer be discovered. The abdomen was reduced to size to which the patient had been long a stranger; and all symptoms of inflammation had disappeared.

Notwithstanding the employment of regular pressure and diuretics, the fluid soon again accumulated, and the abdomen acquired a size even greater than formerly. On the 17th July, the patient was seized with sudden pain, and an extra-

ordinary movement in the abdomen, which phenomena being almost immediately followed by sinking of the median line and enlargement of the sides, indicated that effusion of fluid had a *second time taken place into the peritoneum*. The same series of phenomena occurred as formerly, but they were of less severity. The quantity of urine was also less. The fluid, however, was again entirely absorbed, although somewhat more slowly.

At the end of four months and a half the cyst had again filled; a third rupture took place; there were the same symptoms, but with diminished severity. The urinary crisis was also less abundant, although the absorption was accomplished in ten days.

M. Camus was naturally led by the preceding case to seek for analogous ones among authors, and from a comparison of these, he has deduced some highly interesting conclusions. As regards the termination,—the patients in whom rupture of an ovarian cyst took place into the peritoneum, may be classed under four categories.

1. Into those in whom death occurred immediately, or within a few days of the first rupture. These cases are rather numerous; but, in most, dissection disclosed that the cyst, previous to rupture, had contained a purulent fluid more or less altered, and not the serum usually met with. This circumstance is sufficient to account for the fatal termination of the disease.

2. Into others, who, after one or more ruptures, have remained affected with ascites. Morgagni relates several cases of this kind, some observed by himself, and others by Basius, Gutermann, and Scheeler. It is not, however, demonstrated that in these cases the ascites did not originate at the same time with the ovarian cyst, and previous to the rupture of the latter.

3. It is to be observed that most patients who have survived one or two ruptures were cured only temporarily, and at last sank under the progressive effects of the encysted dropsy. Mauriceau, (*Obs.* 49,) Morgagni, Boyer, (*Maladies Chirur.*) and Bluff, (*Thesis*, by Cazeaux, 1844,) quote examples terminating in this way, which are interesting, as they exhibit a large number of ruptures and peritoneal effusion, followed by absorption of the liquid, without any serious alteration of the general health.

4. There was one patient, who, after several ruptures, was definitely cured of the encysted dropsy. This *unique* case is given by M. Bonfils, and was the subject of a report to the Academy of Medicine, by M. A. Bérard.

M. Camus then puts the following question:—Can art do anything towards rendering the rupture innocuous, and thereby produce a cure of these ovarian cysts? As there is no hope of obtaining a cure, and consequently no end to be served by inducing rupture, provided the cyst contains pus instead of serum, this point ought first to be ascertained by a previous puncture. With this important exception, M. Camus repeats the advice given by M. Bonfils, who recommends, after puncture of the cyst, and previous to withdrawing the canula, to move the instrument somewhat briskly in different directions so as to contuse and even tear the wound made in the walls of the cyst, and thereby prevent the adhesion of its edges, and so to allow a continual escape of fluid from the interior of the cyst into the peritoneal cavity, where it will be absorbed. But can the successful results said to be obtained by M. Bonfils by his method, be thus explained? Ought we not rather to attribute them, with M. Bérard, to the effects of adhesive inflammation—induced by the movements of the instrument—producing obliteration of the cavity? M. Camus admits that the explanation of M. Bérard is the more logical. But he, at the same time, remarks that in the case of rupture, the fluid is not evacuated as after puncture, but remains in the abdomen in contact with the opening into the cyst, and that thus, its pressure must be greatly adverse to the work of adhesion, on which the radical cure depends.

In any case, however, the innocuousness of these ruptures, and the possibility of the re-absorption of the effused fluid, are two facts worthy of the fullest consideration. They ought henceforth to be taken into account in the history of these affections, and would authorize us more than ever to have recourse to a mode of cure more certain and less dangerous than any we yet possess for this formidable species of dropsy, we mean subcutaneous incision of ovarian cysts, or accord-

ing to circumstances the simple puncture, operations already several times proposed by the author of this method.—*Lond. & Edin. Monthly Journal of Med. Sci.*, July, 1845.

50. *Complete Dislocation of the Tibia forwards, produced by simple extension.* By Dr. FELIX JACQUOT, of St. Die.—A serjeant, 21 years of age, of robust habit, entered the Military Hospital of Instruction at Metz, July 23d, 1844. Half an hour afterwards he met with the following accident:—Making a long jump of nearly four yards, upon a flat surface, he fell, contrary to the gymnastic laws, upon the left foot, the leg extended and directed backwards, whilst the right leg, being in advance, did not reach the ground. He experienced violent pain, and fell forwards upon his belly. A dislocation of the tibia forwards had occurred; this was evident, on the simple inspection, from the very marked characteristics of such an accident. It is absolutely impossible to confound it, when recent, with any other lesion.

The thigh formed an obtuse angle with the femoro-tibial articulation, so that the axis of the leg was placed considerably in advance of the axis of the thigh. The superior surface of the tibia was covered by the patella, the subcutaneous surface of which presented forwards and upwards. The condyles of the femur were felt in the popliteal space under the distended skin; but the pulsation of the artery was not felt so superficially as usually described; it was obscured in the space between the condyles. The triceps projected, and the tendons of the crural muscles, inserted internally and externally into the tibia and fibula, were stretched, and formed two bent cords, posterior to the concavity. The limb was very mobile, flexed easily, and without pain; extension was more difficult, and attended with some pain. The foot turned inwards or outwards, according to the position given to the limb. The shortening did not exceed one inch and a quarter.

A swelling, scarcely perceptible, existed at each extremity of the transverse diameter of the knee. The patient suffered very little. No ecchymosis could be perceived, and M. Jacquot was inclined to think that if anything was ruptured, it must be the crucial ligaments, and some fibres of the gastrocnemii muscles; it was evident that the tendons were intact.

Extension was made, and the limb being stretched moderately by three individuals, in a few seconds the reduction was effected. A fracture extension bandage was employed for 20 days, removing it occasionally, when flexion was effected without difficulty by the surgeon, but not by the patient without the assistance of his hands. There was slight swelling the first few days which then subsided. No pain in the knee but pain in the sole of the foot and along the tendo-achillis, particularly at its insertion. This pain lasted a long period, was at times very intense, and did not appear to be caused altogether by the apparatus. When the apparatus was removed, the patient could very partially bend his leg, but, by degrees, the power of voluntary motion returned, and by the 30th of August the power of flexion was, to a great extent, recovered, and he could limp about 20 paces without assistance. The left knee was at this time still somewhat enlarged. On the 3d of September he walked without limping, experiencing only towards the evening rather more than usual fatigue.

M. Jacquot remarks that Velpeau and others deny that a dislocation of the knee can be produced by flexion or extension alone, and that this case tends to invalidate that opinion.

He gives a complicated theoretical explanation of the manner in which this happened, but the simple view of the case taken by the editor of the "*Archives*" is doubtless the true one. "There was not only extension of the leg, but also a rapid fall of the body towards the earth; that is to say, a force which tended to slip the condyles of the femur over the articulating surface of the tibia. It appears to us that the combination of two forces tending to produce the extension of the leg and the rapid fall of the femur downwards, might very easily produce a dislocation of the tibia forwards."—*Ranking's Abstract*, vol. i., from *Archives Générales*, April 1845.

51. *Polypus of the Rectum.* By JAMES SYME, Esq.—Sir A. Cooper states, in his *Surgical Lectures*, that, "in the course of his life," he met with only ten cases of